

Induced abortion: Epidemiological aspects¹

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Sir Dugald Baird sketches the history of abortion legislation in Great Britain from the beginning of the century. In his view the 1967 Abortion Act has been one of the most important and beneficial pieces of social legislation enacted in Britain in the last 100 years. It has, however, brought problems both of administration in the hospitals and to individual doctors and nurses, particularly when the patients are young single women and even schoolgirls. One of the consequences of the Abortion Act has been a fall in maternal mortality and perinatal mortality rates. Abortion does not seem to be followed by serious emotional sequelae. Nevertheless recent changes in sexual mores have introduced new and serious social problems which are discussed in relation to the role of the doctor in his relationship with patients seeking abortion.

The patient with an unwanted pregnancy can present the doctor with one of the most disturbing problems in medical practice and there is a wide difference of opinion on how it should be dealt with. Some doctors consider that induced abortion is murder in all circumstances and that it is never justified. This was the view held by the Roman Catholic priests who paid pastoral visits to patients in the Glasgow Royal Maternity Hospital in the early 1930s and which on occasion resulted in the death of a mother which could have been avoided by termination of the pregnancy. Others think that termination of pregnancy is justified only if the mother's health is very seriously affected. They take the view that increased use of abortion cheapens life and may lead to the wider use of euthanasia. Those who adopt a liberal policy on abortion may consider that human life begins with the birth of the baby. This view receives strong support in a book issued by the American Friends Service Society (1970) entitled *Who shall live?* The working party responsible for its production contained distinguished Quaker scholars, biologists, and medical men, some of whom were professors of obstetrics and gynaecology. It stresses that the quality of life in the home is of paramount import-

ance in determining the child's moral and social attitudes and that 'the punishment of a woman for an unwanted pregnancy and the condemnation of the child to a blighted life to buttress morality are both socially and morally indefensible'. They conclude that no woman should be forced to bear an unwanted child.

In my view the 1967 Abortion Act has been one of the most important and beneficial pieces of social legislation enacted in Britain in the last 100 years. I shall try to show, from a clinical experience as a practising gynaecologist for over 30 years in Scotland, where termination of pregnancy has long been legal, why I hold this view.

Ideally children should be conceived by design and not by accident but it is clear that, human nature being what it is, this will never be possible in practice. Thus while abortion should not be considered as a method of contraception it should be available in the last resort. When one considers the increase in the population due to the effect of the great decrease in infant and child death rates in the last 50 years, together with man's continuing very high fecundity, the strong opposition to birth control has been quite astonishing. As late as the beginning of the present century articles continued to appear in the medical press condemning the use of mechanical methods of contraception. Those who used these methods were described as 'lustful', 'selfish', or 'immoral'. Warnings were given of the harmful physical effects of their use, which included 'galloping consumption, sterility, mental disease, and nymphomania'. A *Lancet* editorial described the use of contraceptives as a 'sin against physiology' (Peel and Potts, 1969).

In 1921 Lord Dawson of Penn, later to become President of the Royal College of Physicians, in an address to a church congress at Birmingham, defended the use of 'artificial birth control' on medical, social, and especially on personal grounds. He asked the Church to revise its opinions on sexual matters in the light of modern knowledge. As the King's Physician, Dawson had virtually put the monarchy on the side of family limitation.

In the early 1930s one third of all maternal deaths in the Glasgow Royal Maternity Hospital were in women who had six or more children. Despite that tragic situation no contraceptive advice was given at any time even to women of high parity. It is scarcely surprising therefore that one third of all

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maternal deaths in Scotland at that time were due to septic abortion. When I went to Aberdeen in 1937 I found the same problems but on a smaller scale. A Marie Stopes contraceptive clinic had been in existence since 1925 but was not well patronised. Termination of pregnancy and sterilization were therefore offered to those in most urgent need of help, despite the great practical difficulties of staffing during the war years and inadequate hospital accommodation.

After the war and as a result of increased facilities, it became possible to offer postpartum sterilization and by 1961-63 the overall incidence was 4.5 per cent, 25 per cent in those who had five or more children. Two per cent of women had an induced abortion each year and hysterotomy followed by sterilization was performed more often in social classes IV and V and curettage more often in classes I and II. At that time relatively few single women requested termination of pregnancy and they came largely from classes I and II. Social classes IV and V were overrepresented in the women having postpartum sterilization.

The results of these procedures were excellent from the patient's point of view and the policy had strong support from the family doctors concerned.

Contraceptive service

The local health authority took over responsibility for the contraceptive service in 1964 and integrated it with the maternity and child welfare service. Despite all the efforts to bring this service to the notice of mothers, and the fact that it was given virtually free of charge, attendance increased rather slowly until oral contraception was introduced at the beginning of 1964. The number of first attendances increased from 200 in that year to 1100 in 1972. An equal number of women received advice from their family doctor. The number of women who had *postpartum* sterilization performed increased from 200 in 1961 to 600 in 1972 and since 1970 the number of vasectomies performed has increased rapidly. These preventive measures caused a reduction in the birth rate from 1957 onwards.

The birth rate since 1946

The birth rate in Scotland rose steeply in all parities between 1946 and 1948. This was largely the result of births which had been postponed during the war years. It rose again in first pregnancies from 1952 onwards. This was related to an increase in the marriage rate and to a decrease in the age of marriage, possibly as a result of better socio-economic conditions. A new factor from about 1958 onwards was an increase in the illegitimacy rate, particularly in single women. It occurred first in the non-manual occupational groups but before long these young women began to attend the local

authority contraceptive clinics and the number of pregnancies in this group decreased. Meanwhile the number of pregnancies and births increased in the manual occupational groups and finally in schoolgirls. For example, in England the number of births in those aged 16 or under increased by 9 per cent between 1971 and 1973 while in those aged 17-19 the number decreased by 9 per cent during the same period. It is clear that the higher incidence of pregnancy in single women was not the result of the Abortion Act. In fact the acute problem which resulted from the requests of large numbers of young single women to have a pregnancy terminated may have rendered legislation to liberalize the law on abortion more urgent and increased the support for the Bill in the House of Commons. Requests for abortion have also caused administrative difficulties for hospitals, and have been much more emotionally disturbing to doctors and nurses than similar requests from married women. In Aberdeen the incidence of so-called 'spontaneous' abortion in illegitimate pregnancies fell from 16 per cent in 1965 to 8 per cent in 1972 - the naturally occurring rate in legitimate pregnancies. The incidence of induced abortion rose from 12 to 52 per cent. In married women 7 per cent of pregnancies were terminated. The net result is that approximately 15 per cent of all pregnancies were terminated in 1972.

Consequences of abortion policy

The maternal mortality rate from abortion (all types, spontaneous and induced) in England and Wales has fallen from 0.68 per 100 000 births in 1963-66 to 0.38 in 1969-72. In fact the number of deaths following abortion (all types) in 1973 was the lowest on record (10 compared to 23 in 1972, equivalent to a rate of 0.15 per 100 000). The incidence of resultant damage to the pelvic organs is not known precisely. The risk of subsequent infertility is of particular importance in young single women but it is precisely in this group that serious objections to systematic follow-up studies exist. It might also be distasteful to married women attending an antenatal clinic with what is presumed to be their first pregnancy if they are interrogated about the possibility of a previous induced abortion.

Apart from the inevitable and immediate stress associated with the termination of a pregnancy, emotional sequelae are surprisingly few, especially if the operation is performed early and if kindness and understanding are shown by doctors, nurses and relatives. There is no doubt that termination of pregnancy has brought great relief from acute mental stress to many women in the North East of Scotland. The fact that very few of those who have been refused terminations have gone elsewhere suggests that those most in need have had the pregnancy terminated. Information of this kind

can be obtained fairly easily under the conditions which exist in a relatively small area such as the North East of Scotland where there is little movement of population and very good integration of the three parts of the National Health Service. The results of a recent comprehensive research programme in Aberdeen agree with the conclusions on psychological sequelae drawn from many years of clinical observation.

It is not surprising that throughout the UK family doctors, who have had the advantage of continuity of care of their patients, favour a more liberal policy on abortion than obstetricians who are usually obliged to make decisions without the detailed information about the patient and her background.

There is no doubt that the efficient organization of a comprehensive family planning service has contributed to the very low perinatal and infant mortality rates in Aberdeen. For example, one quarter of the decrease in the number of births between 1965 and 1972 was the result of fewer fifth or later pregnancies. Only 25 per cent of the women having a fifth pregnancy had already had four viable children. The rest, having had abortions or perinatal deaths, were in fact planning a family of not more than two or three children. Fifty per cent of them asked for postpartum sterilization and had the operation performed. Between 1958-62 and 1968-72 the number of perinatal deaths in fifth or later pregnancies was reduced by 75 per cent compared to 55 per cent in all other pregnancy groups. The great reduction in the number of births to women of high parity therefore made a substantial contribution to the fall in the total perinatal mortality rate.

The incidence of induced abortion in four of the five regions of Scotland rose from 55 per 1000 (live and stillbirths and abortions) in 1969 to 145 in 1973. In the Western Region it rose from 30 in 1969 to 70 in 1973. In all regions the rise in incidence was very slight in 1973. This is also happening in England and Wales with regard to British residents. The overall rate in Scotland of 100 is much lower than in England and Wales because 58 per cent of all births in Scotland take place in the Western Region. In Glasgow, the centre of the Western Region, the birth rate (per 1000 women aged 15-44) is 20 per cent above that of the combined rate for the other three Scottish cities and the illegitimacy rate per 1000 unmarried women is twice as high. The perinatal mortality rate in Glasgow is 20 per cent higher than the rate in the other cities. These very high rates, especially the high illegitimacy rate, are important contributory factors to the notoriously high incidence of disease, delinquency and crime in Glasgow. In England and Wales the abortion rate is lowest and the perinatal mortality and birth rates highest in the industrial north, especially in the large conurbations such as Liverpool and Manchester where serious social problems similar to

those in Glasgow exist.

One may conclude therefore that in four of the five Scottish regions there seems to be close agreement on the need for a liberal abortion policy amongst the leading obstetricians and gynaecologists and the family doctors with whom they work. It is also recognized that, while everything must be done to improve contraceptive methods and to bring them to the notice of the public, abortion is still necessary and quite clearly the lesser of two evils when pregnancies which are definitely unwanted occur. The comparatively low abortion rate in the Western Region is due partly to the existence of a large Roman Catholic minority but basically to the anti-abortion views of several of the leading obstetricians in the region.

Recent changes in sexual mores have created new and serious social problems, however. In Aberdeen in 1971 out of each 100 pregnancies in primigravidae, aged 15-19, 20 were terminated. In 23 cases the baby was born illegitimate. Less than 20 conceptions occurred after marriage. The size of the problem is shown by the fact that 35 per cent of all confirmed first pregnancies in Aberdeen in 1971 were in the 15-19 age group. By contrast, in the 25-29 age group, in which 16 per cent of all first conceptions occurred, 70 per cent resulted in the birth of a baby which had been conceived after more than one year of marriage. In England and Wales the divorce rate rose sharply between 1962 and 1971. The rise was most acute in those who were married before the age of 20 and especially in those who had been married for not more than four years.

Discussion

Women of the previous generation, especially those in social classes IV and V, were either resigned to having large families or lacked the confidence to ask for help to escape the tyranny of continuous childbearing. Today sterilization is being requested by women in all social classes after the second or third child. Husband and wife are prepared to accept the responsibility for their decisions and expect to have their requests granted. Twenty years ago doctors had to put forward the idea of sterilization cautiously, but today it may be the patient in her middle twenties with two children who persuades the family doctor or the obstetrician that sterilization is desirable. Even more remarkable is the willingness of husbands in all social classes to have vasectomy performed. The reason given for limiting family size is almost invariably the cost of living and giving the children a 'good start in life'. For some a return to work outside the home by the mother is essential to accomplish this. Others wish to continue a career in business or a profession. Very few give overpopulation as a factor influencing their decision on family size.

The doctor's role has changed as society has changed. He should act more in an advisory capacity by helping the patient to make the wisest decision for her in the light of all the facts both medical and social. One should not lose sight of the fact that the mother's commitment is not only for the nine months of pregnancy but for the next 16 years at least, while the child is growing up. The quality of the environment in the home greatly influences the opportunities open to the individual.

The doctor-patient relationship differs in the case of a request for abortion from that in most other circumstances, because the patient can make the diagnosis that she is pregnant and can assess her personal situation. I have gradually come round to the view that abortion on request is the most realistic attitude to adopt in the present state of society, and, that while doctors should not be forced to recommend or perform abortions if they have deeply held convictions that such a procedure is wrong, they have a duty to help a patient to have access to doctors whose views are more in line with their own. I think that more patients (especially immature and inexperienced young women) would turn to their family doctor for help if they were more confident that he would discuss their problem dispassionately even if, in the end, he did not agree with their point of view.

The present failure to prevent unwanted pregnancies despite the availability of reliable methods of contraception, if not surprising, is very disappointing. Clearly more needs to be done to improve the level of general education. The efforts of parents, teachers, doctors, nurses and social agencies must be increased and better co-ordinated.

The development of health centres in which a number of doctors work suggests that the future lies in team work, with some doctors having a special interest and postgraduate training in a particular aspect of medicine in addition to their vital role as a personal doctor to those on their list. This would widen the responsibility of the general practitioner group for diagnosis and therapy.

The medical graduate, because of his knowledge of physiology, endocrinology and psychological medicine and his continuity of care of his patient and his family, will, provided he has the right type of personality, make a more effective counsellor than those who are not medically qualified and do not have these responsibilities. He should therefore coordinate the activities of parents, teachers, nurses and social workers. The general practitioner with a special interest in sex and reproduction should coordinate the work of his colleagues in this field and should be the link between the health centre and the appropriate specialist department in the central hospital or medical school.

References

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Commentary

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Sir Dugald Baird's article concludes that 'abortion on request is the most realistic attitude'. Politicians will misuse this statement. Perhaps the writer's influence could be rechannelled when he learns of the situation in Denmark where abortion on demand is practised. I qualified in London but obtained specialist status in obstetrics and gynaecology in Denmark and therefore take the liberty of reviewing Professor Baird's paper.

The 1930s and the present situation

'The death of a mother which would have been avoided by termination of pregnancy' is inferring that Roman Catholic priests (I'm not a Roman Catholic) were sometimes responsible for such deaths. However, in the 1930s the writer states that one third of deaths occurred in multiparae (no doubt due to prevailing obstetrical standards) and that one third of maternal deaths were due to septic abortion. The remaining one third is not quoted, presumably because there is no absolute evidence that if a fetus is not removed the mother will die.

No obstetrician can prove absolute demands for induced abortion but only relative ones, depending on the doctor-patient relationship. The problem with sick pregnant women is knowing how to prevent spontaneous abortions or premature births. The present rate of sepsis following legal abortion is still too high, and I am sure that abortion on demand in the 1930s would have created some septic legal abortions.

'No woman should be forced to bear an unwanted child': but what are the rights of the father if he wants the child? No child is unwanted in Denmark, as we have a very long waiting list of childless married couples awaiting a child for adoption. Children are a luxury commodity here.

Abortion as a method of contraception

'Abortion should not be considered as a method of contraception': Danish statistics show that legal